AFSCME
We Make Pennsylvania Happen
HEALTH AND WELFARE FUND

Dependent Attestation Form
(for Dependents to Age 26)

Note: All information requested below MUST be provided.

Member Information (Please print clearly or type)

1. Last 4 digits of your Social Security Number _____
2. Name (First, Middle Initial, Last) _____
3. Address: Street: _____
   City: _____ State _____ Zip Code _____
4. Date of Birth: _____

The dependent must continue to be enrolled in the same plan(s) in which the member is enrolled. To continue dependent coverage to age 26, this form must be completed and returned to the Fund within 30 days.

Dependent Information (Please print clearly or type)

5. Last 4 digits of Social Security Number _____
6. Name (First, Middle Initial, Last) _____
7. Is Dependent's address same as the member's? Yes ___ No ___
8. Address: Street: _____
   City: _____ State _____ Zip Code _____
9. Telephone number Home: _____ Work: _____
10. Date of Birth:: _____

Please answer the following questions

Is the Dependent eligible for other employer-sponsored medical and prescription coverage (other than through a parent)? Yes ___ No ___

Does the employee have other employer-sponsored medical and prescription coverage (other than through a parent)? Yes ___ No ___

If yes, what was the effective date of coverage? _____

Name and Address of Dependent's employer

_____

_____

_____

I certify that this information is correct to the best of my knowledge. By signing this certification, I am authorizing the Fund to continue coverage for my Dependent to Age 26.

Member's signature: _____ Date signed: _____

Note: Eligibility for benefit coverage for dependents to age 26 and continuation of this coverage is subject to periodic evaluation and recertification. Should Dependent or any other information on this form change, benefit coverage may be reconsidered by the Fund.